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F 324	Continued From page 16 codes for all visitors exiting the front doors preventing the alarm from sounding. If an alarm does go off staff are instructed to check to see if it is a resident, if so the alarm is to continue to sound until the resident is brought back into the building. This was included on the inservice to all staff completed on 11/11/05 for Door Alarms conducted by E2, Administrator. 8. Starting on 11/10/05 residents assessed at high elopement risk were placed on a 1:1 staff monitoring until the installation of electronic remote/bracelet type alarm system was installed on the front entrance doors. 9. Installation of an electronic remote/bracelet type alarm system was installed on both front entrance doors on 11/12/05 by an electrician contracted from a lock/alarm business. All staff inserviced on the new system and the Resident Monitoring Policy on 11/12/05 or at the start of their next scheduled shift was conducted by E2, Administrator. 10. All Elopement Assessments were updated for accuracy and were completed on 11/10/05. Care plans will be updated as needed to reflect any changes from the Elopement Assessments on 11/10/05 by E11, Director of Clinical Operations.	F 324		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1210a) The facility must provide the necessary care and services to attain or	F9999		

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maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

300.1210b)4) Personal care shall be provided on a 24-hour, seven-day-week basis.

300.3100d)2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24-hour-a-day supervision of the door, a signal is not required.

Based on record review, observation, and interview the facility failed to implement care plan interventions to provide adequate supervision for one of three residents (R1) identified as high elopement risk in order to prevent R1 from leaving the building unattended; specifically failed to monitor the front entrance doors closely when visitors leave; failed to offer activity - small task to occupy resident's time; and failed to increase supervision when increased wandering was observed by staff.

Findings include:

According to the facility's Incident Report Form - IDPH (Illinois Department of Public Health) Notification, R1, age 83 was located outside the building on 10/26/05 at 4:28pm. According to the

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report form staff were made aware that R1 was outside and brought R1 back in at 4:45pm. According to the Final Report dated 10/31/05 staff completed a head count of all residents and verified that R1 was the only missing resident. All door alarms were checked twice and found to be functioning properly and the appropriate staff were notified immediately.

E5, Dietary/LaundryAide, on 11/9/05 at 1:55pm stated that she was working in the laundry on 10/ 26/05 when she answered the phone at 4:28pm. R1's wife had called the facility from her home phone to tell them that R1 was just found by an employee outside of a business located just south of the facility and wanted someone to go get R1. E5 stated that she immediately told E6, Licensed Practical Nurse (LPN), about the phone call.

R1's November 2005 Physician's Order Sheet includes as part of the diagnoses Dementia and Anxiety Disorder. R1's current Physician's Order Sheet includes the following medications: Ativan 1 mg (milligrams) three times a day and half a tablet at bedtime, Zoloft 1/2 50mg tablet at 5pm, and Trazodone 100mg at bedtime.

R1 was admitted on 4-21-04 and according to R1 's Elopement Risk Assessment Form Dated 4-29-04, R1 is at risk for elopement (leaving the facility without staff knowledge or supervision). The form indicates that the resident wanders and has had one or more attempts of elopement at this facility. A note was added to this form "A fifteen minute watch was put out for resident from day of admit." The form indicates that the resident (R1) has the (physical) appearance of a visitor.

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F9999	Continued From page 19 According to R1's last Fall Risk Assessment Form dated 8-3-05 R1 ambulates independently without any devices. Physical Restraint Elimination Review Form dated 8-3-05 shows no restraint was being used at this time. This form indicated that R1 was disoriented with a short attention span. R1's ambulation was with a steady gait, full weight bearing and had some impaired vision. R1's Quarterly Psychotropic Assessment dated 8 -3-05 documents "(R1) continued to have periods of confusion and exits door. (R1) much calmer, easier to return to inside of facility. Resident attending activities and enjoying helping in facility ." R1's Care Plan dated 4-27-05 added "Continues to express desire to leave and attempt to exit building, increased number of attempts in afternoon/early evening." The interventions include the following: Redirect away from exit doors. Monitor doors closely when staff or visitors exit. Remind staff/visitors to always look behind themselves when exiting facility/unit. Continue 15 minute visuals, M.D. (Medical Doctor) to do med review, activities to assess resident for activity capabilities for late afternoon and early evening. These interventions were still on the current care plan as reviewed on 7/2/05. The Behavioral Observation Monthly Flow Chart for the month of October 2005 for the behavior identified as "Wandering (Elopement Risk)" shows that staff documented this behavior on four different days on the 1st shift and seven	F9999		

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different days on the 2nd shift. The second page of documentation lists a behavior as: "Socially inappropriate (Resident will become verbally abusive, could become physically abusive, resist care when redirected when wandering.)" There is only one day that has 10 episodes listed for one day on second shift, all the others are entered as "0."

E7, Certified Nurses Aide (CNA), at 2:55pm on 11/9/05 stated that prior to R1's elopement on 10/ 26/05 rarely a day went by that R1 did not try to get out the door on the 2nd shift, usually it was multiple attempts. E7 stated that if staff are not right there R1 is right out the door and most of the time it would take two staff to get R1 back in the door. When questioned about documenting on the second page of the behavior sheet, E7 indicated that was only if R1 was verbally or physically aggressive. E7 was surprised that it included the third part about resists care when being redirected when wandering. E7 stated that happens all the time. E7 stated that none of the other staff probably know that is on the documentation sheet. When asked what R1 had been like the last few days for elopement attempts, E7 indicated that on November 7 and 8 , 2005 R1 had elopement attempts that were 10 times or more for the second shift. According to the Behavioral Observation Monthly Flow Chart on October 19, 20, 22 and 23 all have entered 10 + for elopement attempts for the 2nd shift.

Interview with E8, CNA, at 3:00pm on 11/9/05 stated that on the 2nd shift R1 may try to go out the door 5 to 7 times during the shift. E8 stated the behavior of attempts to go out the door is about the same now as before the elopement.

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F9999	Continued From page 21 E9 (CNA), stated on 11/9/05 at 3:30pm that somedays R1 does not attempt to go out and other days it is non-stop. E9 stated that R1 will state that he wants to go home, R1 states he is looking for his car or he needs to go see his wife. Observation of R1 on 11/9/05 from the end of lunch until 1:45pm showed R1 wandering the facility looking out doors and windows with no attempts to open doors. There were no staff interventions to engage R1 in any activities at this time. At 1:50pm R1 attempted to go to the North Entrance door but was stopped by staff and the alarm. At this time E1, Social Service Director (SSD), offered a beverage and an activity for R1, which R1 declined. R1 did not want to sit down. R1 walked away and went down the West hall by himself. R1 continued to set off other alarms at least 5 times from 1:50pm until 4:00pm at various exit doors, each time with staff intervention required. R1 on 11/10/05 at 9:00am to 9:35am was in the dining room sitting in a chair looking out a window. R1 made no attempts to open any doors. Observations continued until 9:50am during which time staff gave R1 a puzzle to work on. During this time R1 made no attempts to exit the building. Observations of R1 from 2:30pm until 3:57pm continued with R1 in the dining room where staff had given R1 some cards to sort that kept R1 occupied from 3:10 until 3:50pm. By 3: 57pm R1 was up walking again. E2, Administrator, at 11:10am on 11/9/05 stated that the investigation showed that the door alarms did work, they were checked immediately	F9999		

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by staff, and the alarms had not sounded prior to R1 being found missing from the building. E2 stated that they felt that R1 must of held the door for a visitor then just continued on out the building.

Interview with E1, SSD, at 9:25am on 11/9/05 stated R1 liked to hold the door for visitors, he was a gentleman, if there were people coming or going he would hold the door for them. E1 stated they had a new resident admitted on 10/26/05 and family was probably bringing in things for this resident through the front doors where the code alarms are. They would put in the code numbers so the alarms would not go off, and R1 may have held the door open for them so they could carry in their items and then just continued on out the door.

E4, Director of Nursing (DON), on 11-9-05 at 1: 15pm stated that "(R1) liked to do small jobs in the facility like straighten the magazines, one day he dusted the handrails with me." E4 said that R 1 "was more sundowners, he gets worse with wandering as the day goes on." Dementia residents with Sundowners with known behaviors tend to have a higher intensity of those behaviors as the afternoon and evening approach.

E6, LPN, at 2:30pm on 11/9/05 stated that if R1 is in a wandering mood sometimes they will get out his cards to sort or a puzzle and R1 would sit for you. E6 also stated that if the girls are busy on the back hall E6 would keep an eye on R1 because the front door alarm is hard to hear if the CNAs are on the back hall. E6 stated that sometimes R1 just likes to "sit and chit chat." E6 stated she was down on the back (400 Hall) hall,

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after doing an assessment on the new resident when E6 was told by E5 about the phone call about R1 being outside of the building. E6 told the other nurse on duty and the Certified Nurses Aides (CNAs) about the phone call immediately. E6 stated the CNAs were sent to do an immediate head count of all residents. E6 stated that she and the other nurse on duty went around and checked each of the door alarms to make sure they worked correctly. E6 stated at the conclusion of the head count the CNAs determined that R1 was the only resident that was not in the facility.

The Resident Monitoring Log for R1 dated 10/26/05 monitors R1's location, activity, mental state, and intervention. Staff had documented that R1 was hallway wandering at 3:30pm, 3:45pm, 4:00 pm and 4:15pm all without any interventions noted. R1's mental state was listed as confused during all entries for the day. At 4:30pm staff noted "Resident missing - out looking for resident, received phone call from wife at 4:28 pm. Back in building at 4:50pm."

Interviews with E7 and E8, CNAs at 2:55pm and 3:00pm on 11/9/05 stated they were both sent out to check the immediate grounds of the facility after completion of the resident head count. After returning back into the building and not locating R1, E7 stated that the nurse, E6, sent both E7 and E9, CNAs, over to the business located south of the facility. E7 stated the weather was clear, sun was shining and they did not need a jacket on that day.

According to the Final Report dated 10/31/05 R1 was appropriately dressed in blue jeans, two T-

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shirts, flannel shirt and boots. This was confirmed during the interviews with E7, E8 and E9, all CNAs on 11/9/05 at 2:55pm, 3:00pm and 3:30pm.

The Nurses' Note dated 10/26/05 4:28pm includes information about the full body assessment after being returned to the facility. "(R1) has an abrasion to the right knee and right elbow and left pinky finger." E1 on 11/9/05 at 9: 25am stated that R1 had a grass stain on one knee of his light colored blue jeans.

Z1, the Maintenance person from the business located south of the facility, was interviewed at 12 :00pm on 11/10/05 and indicated that R1 was observed to be standing on the small paved roadway that runs between the main building and the Distribution Building. R1 was standing where the road runs more East/West near the railroad tracks. Z1 stated that R1 was taken to the office in the Distribution Building where R1 was able to tell the employee his name and they located a phone number to his wife's residence in Shelbyville. Z1 stated that there are always some railway boxcars on the tracks everyday. They have a small track mobile engine that is used to move the cars on the tracks. Z1 indicated regular size engines do not come this far down the tracks to get the boxcars.

On 11/10/05 at 9:45am with E1, SSD, a walk of the grounds was conducted to see the area that R1 may have traveled, and showed that on the East side of the facility is a fairly flat grassy area to walk. Behind the facility and slightly to the East is an enclosed fenced-in electric power transformer station. At the far South East edge

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F9999	Continued From page 25 of this is a ditch with large rocks. During times of rain the ditch collects the run off from rain. At this time the ditch was dry. Past the plant parking lot and toward the railroad track there is a ditch that drops down about a foot and then has a rise of about 3 feet on the other side. The rocks along the two sets of rail road tracks are about half the size of a fist. There is about a four foot drop down a grassy slope on the other side. This is quite a distance from where R1 was found according to Z1. R1 would have had walk along the railroad tracks or cross the four sets of tracks by the plant parking lot. The tracks by the plant parking lot are set similar to a common railroad crossing with asphalt between the rails. About one tenth of a mile North from the facility there is a busy highway (Route 16) located just past the shopping center that sits in front of the facility. Interview with R1 at 10:45am on 10/9/05 confirmed that R1 does not have any safety awareness when crossing a busy road. R1 did not know what to do when coming to a road and there are cars on the road. (A)	F9999		